GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

September 19, 2023

Sara Dickendesher
Glen Abbey Assisted Living, LLC
Suite 200, 3196 Kraft Ave.
Grand Rapids, MI 49512

RE: License #: AH820372250
Investigation #: 2023A0585072
Glen Abbey Assisted Living

Dear Ms. Dickendesher:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Brender L. Howard

Brender Howard, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(313) 268-1788

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH820372250
Investigation #:	2023A0585072
Complaint Receipt Date:	06/30/2023
Investigation Initiation Date:	07/19/2023
Report Due Date:	09/30/2023
Licensee Name:	Glen Abbey Assisted Living, LLC
Licensee Address:	Suite 200 3196 Kraft Ave. Grand Rapids, MI 49512
Licensee Telephone #:	(616) 719-4332
Administrator:	Julie Edwards
Authorized Representative:	Sara Dickendesher
Name of Facility:	Glen Abbey Assisted Living
Facility Address:	445 North Lotz Road Canton, MI 49512
Facility Telephone #:	(734) 981-9224
Original Issuance Date:	07/21/2017
License Status:	REGULAR
Effective Date:	01/21/2023
Expiration Date:	01/20/2024
Capacity:	64
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A stubbed her toe and sustained a swollen ankle.	No
Staff need more training.	No
Additional Findings	Yes

III. METHODOLOGY

06/30/2023	Special Investigation Intake 2023A0585072
07/19/2023	APS Referral Referral sent to Adult Protective Services (APS)
07/19/2023	Special Investigation Initiated - Telephone Contacted complainant for additional information.
07/21/2023	Inspection Completed On-site Completed with observation, interview and record review.
08/11/2023	Contact - Telephone call made. Contacted administrator Julie Edwards to discuss allegations.
08/11/2023	Contact - Telephone call made. Attempted contact with Attorney General Office, Drew Macon to discuss allegations. A message was left return call to discuss allegations.
08/11/2023	Contact - Document Received Email received from Attorney General Drew Macon regarding allegations. His office decided not to investigate and referred it to LARA.

ALLEGATION:

Resident A stubbed her toe and sustained a swollen ankle.

INVESTIGATION:

On 7/18/2023, the department received the allegations from the Attorney General (AG) office via the BCHS Online Complaint website. The complaint alleged Resident A was being transferred into her lift chair from her wheelchair and complainant was told that Resident A snubbed her toe and she was fine, but it is believed that she had a fall or had gotten leg stuck/wedged in something.

On 7/19/2023, a referral was sent to Adult Protective Services (APS). The investigation was assigned to APS worker Tomeka Beans.

On 7/19/2023, I interviewed complainant by telephone. The complainant stated that Resident A's fibula is broken. The complainant stated that the facility called her at 9:45 p.m. stating that Resident A stubbed her toe, and she was fine. She stated that the next morning at 9:30, the facility called her back stating Resident A's ankle was swollen and she was hallucinating. She stated they sent her to the hospital to have both ankles looked at. The complainant stated that the nurse called her back and told her that when she questioned the staff and was told that Resident A's foot got stuck and they still proceeded to put her in her lift chair. She stated the staff member changed her story several times.

On 7/21/2023, an onsite was completed at the facility. The administrator Julie Edwards was not in the facility at that time. I interviewed wellness director Tiffany Wogama at the facility. Ms. Wogama stated that during a transfer, Resident A's foot got caught under the leg bar. She stated that Employee #1 did not notice that Resident A's foot was caught. She stated that Resident A complained of pain, and they elevated her foot. She stated that when staff saw Resident A the next morning that her foot was bruised. She stated that Employee #1 got a warning because she did not report it immediately. She stated that Employee #1 was written up and re-educated. Ms. Wogama stated that they suspended Employee #1 that improperly transferred Resident A but they eventually fired her.

On 8/11/2023, I interviewed Ms. Edwards by telephone. Ms. Edwards statement was consistent with Ms. Wogama. Ms. Edwards stated that they were not able to get a straight answer from Employee #1 involved in the transfer of Resident A. She stated they made the decision to terminate Employee #1.

On 8/11/2023, I received an email from AG Drew Macon. He said that the AG office did not open the case and referred it to LARA for investigation.

On 8/16/2023, I spoke with APS Worker Ms. Bean who stated that she will be substantiating based on neglect.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Resident A sustained injuries due to improperly transferring by staff. It is not known how it happened due inconsistency from the staff. The facility suspended staff and upon further investigation staff was terminated. Document notes that staff were trained in the properly transferring of resident. Therefore, the facility reasonably complied with this rule.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Staff need more training.

INVESTIGATION:

The complainant stated that the staff in the community needs more training or supervision.

Ms. Edwards and Ms. Wogaman both stated that all staff are trained in the proper way of transporting residents. They stated that additional training is also given as needed.

Documents showed that staff training consisted of lift training, preventing falls, and reporting and documentation. Documents showed that Employee #1 had training that included lift training and reporting.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(6) The home shall establish and implement a staff training program based on the home's program statement, the residents service plans, and the needs of employees, such as any of the following:

	(a) Reporting requirements and documentation. **(b) First aid and/or medication, if any.** **(c) Personal care.** **(d) Resident rights and responsibilities.** **(e) Safety and fire prevention.** **(f) Containment of infectious disease and standard precautions.** **(g) Medication administration, if applicable.**
ANALYSIS:	Document show that staff had training that included transferring and lift training. Therefore, this claim could not be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS

INVESTIGATION

Ms. Edwards said that Employee #1 was the only staff that was in the room during the transfer of Resident A.

Service plan for Resident A read two persons assist with bathroom assistance, transfers with Hoyer lift or sit to stand and two people assistance required.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.

R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident's activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	There were only one staff present during the transfer of Resident A. Therefore, the facility did not comply with this rule.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, it is recommended that the status of the license remains unchanged.

09/19/2023

Brender Howard Date
Licensing Staff

Approved By:

09/19/2023

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section